

# Education and debate

## Confronting Africa's health crisis: more of the same will not be enough

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The international community needs to rethink its approach to Africa if it wants to produce sustained improvements in health

At current rates of progress, sub-Saharan Africa will not achieve any of the millennium development goals.<sup>1</sup> In health, the situation is especially bleak, with little or no substantive progress since 1990. All key health indicators are at much worse levels than those in any other of the world's developing regions (with the exception of malnutrition in children under 5 in South Asia, but there the situation is improving).<sup>2,3</sup> In this article, we critically examine the main approaches currently supported by the international community for accelerating progress towards the health related goals—increased aid, reform of the health sector, and global health initiatives—and outline an alternative approach for improving the health of African people.

### Why is the health of people in Africa so poor?

At the heart of the poor state of health in Africa lies a failure to tackle extreme poverty. Today, 46% of the population live on less than \$1 (£0.55; €0.82) a day, a greater proportion than 15 years ago.<sup>1</sup> The failure to tackle poverty is due to several inter-related factors, mainly economic stagnation and the related debt crisis. Support from the International Monetary Fund and World Bank for countries with crippling debt has been contingent on governments adopting painful structural adjustment programmes. These have required countries to put strict ceilings on government spending in the social sectors, limit public sector recruitment, and liberalise trade.

National institutions in many African countries are often weak, leaving governments open to corruption, and conflict has affected several African countries with devastating consequences for health. HIV and AIDS have undoubtedly contributed. On average, 1 in every 14 adults in Africa is infected with HIV, a rate much higher than in any other part of the world. The resulting pressures on health workers are immense, and the situation described by a clinical officer in Malawi (box 1) is by no means unique.

### Increasing overseas aid and debt relief

Increases in aid and debt relief are welcome, but alone they do nothing to tackle many of the issues that are at



People gather at a mobile clinic to receive health care

the core of the health crisis in Africa, notably the unequal conditions of trade, inappropriate health sector reform policies, and fragmentation of health systems. The increases recently committed by the G8 are not nearly enough to meet the millennium development goals.<sup>4</sup> In addition, as much of the money will be delivered as debt relief and taken from aid budgets, it may decrease the flow of aid.

Another issue is the shift in the preferred method of delivering aid. Instead of supporting specific projects, several major donors, including the United Kingdom and European Union, are delivering increasing amounts of their official aid as general budget support. Budget support has several advantages; most importantly, it increases ownership of aid by developing countries and promotes investment in a single national expenditure programme. But although increased budget support has led to improvements in some important health outcomes in a few countries, especially those related to child health (box 2), the overall picture is mixed.

Donors providing budget support usually require governments to increase their social sector spending, but increases in spending on health do not necessarily follow (primary education has generally done better in

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**Box 1: The reality for health workers in Africa**

Fred Zayinga is a senior clinical officer in Chikwawa District, situated in the densely populated south of Malawi. When we visited him in August 2005 he was acting district health officer for a population of about 500 000. He trained as a medical assistant from 1975 to 1977, worked for 10 years, and then received two years' further training to become a clinical officer.

Mr Zayinga is competent in all branches of medicine; he casually informed us that he had recently done an emergency hysterectomy for a ruptured uterus on a woman with obstructed labour. Chikwawa District Hospital has 300 beds and covers one 50 bed rural hospital and 20 health centres. Health centres are staffed by medical assistants, nurses, and, increasingly because of staff shortages, health surveillance assistants with only 10 weeks' training. Mr Zayinga admitted that monthly supervisory visits to the clinics had, for the past year, been curtailed because of staff shortages and delays in receiving their travel budget. Non-emergency surgery has been stopped at the district hospital for about six months because of lack of equipment and supplies such as suture material, gauze, and cotton wool. The laundry equipment broke down six months ago. The equipment had also recently broken down in Nsanje Hospital, some 100 km away, where laundry had been sent as an interim measure.

His workload has increased greatly in recent years, with HIV and AIDS being largely responsible. More recently, the drought has led to many more cases of severe child malnutrition. The new antiretroviral treatment programme has created additional challenges. "Things are worse than in the 1980s: they started going downhill in the 90s, and got worse still when nurses started leaving for the UK about five years ago," Mr Zayinga said. "There has also been internal robbery by external funders and the mission hospitals, which pay better."

this regard). Furthermore, although overall government expenditure on health is very low in Africa (typically around \$6 per person), the money is mostly spent on providing services such as tertiary hospitals, which are expensive and mainly benefit the better off. Non-governmental organisations such as churches, which are important providers of health care to deprived populations in many African countries, may not benefit from increased aid flows to government.

**Health sector reform**

The structural adjustment programmes demanded of many African countries during the 1980s and 1990s included reform of the public sector. Although the stated aim was to increase access to high quality health care, in reality the reforms focused on reductions in public expenditure and reducing the role of the state, regardless of the local contexts.<sup>6</sup> Health sector reform has affected public health services through at least three of its key strategies: the quest for efficiency through rationalisation of staff and delivery of a core set of essential services; greater involvement of the private, for profit sector; and decentralisation. Here, we focus mainly on the first of these.

Cost effectiveness analysis is increasingly used to define essential services. For example, proponents of this approach recommended that promoting good

hygiene was more cost effective than improving water supply and sanitation to reduce diarrhoea.<sup>7 8</sup> However, the many potential indirect effects of improved water and sanitation on health, such as reduced skin and eye disease and improved household agriculture, were excluded as benefits because they are difficult to compute. At the same time, the costs of providing water and sanitation were all unfairly ascribed to the health sector because diarrhoea was the outcome. The approach has narrowed the scope of public health, reducing it to a set of technical interventions and ignoring the determinants of ill health. Comprehensive strategies that aim to tackle major health problems and sustainably improve the lives of those living in poverty have been undermined.

Health interventions other than those defined as essential are increasingly funded by user fees and community based financing or transferred to the private sector. Thus health care has become rapidly commercialised. For example, by the late 1990s only 9% of healthcare transactions studied in Tanzania were provided free of charge.<sup>9</sup> The effect on the poor in terms of reduction of access to health care and the impoverishing effects of illness are well documented.<sup>10</sup> Overall, the demise of the public health system has been accompanied by a reduction in the capacity and legitimacy of the state to provide a fundamental service to its population; across the continent, community based health programmes were dismantled and cadres of community workers lost.

**Global health initiatives**

The past 10 years have seen a massive growth of global programmes focused on specific diseases. The largest of these—the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance on Vaccines and Immunisation (GAVI)—have billion dollar budgets and are major sources of health financing in the poorest countries. A plethora of smaller initiatives have sprung up in their wake with a focus on everything from epilepsy to elephantiasis.

Many global programmes are centred around providing funds for specific technical interventions such as new drugs and vaccines. The Global Fund targets 49% of its expenditure on drugs and commodities such as antiretrovirals and new antimalarials but only 20% on human resources and training.<sup>11</sup> The Global Alliance

**Box 2: Child and maternal health in Tanzania**

- Mortality in children under 5 years fell from 147 to 112 deaths per 1000 live births between 1999 and 2004<sup>5</sup>
- The proportion of children sleeping under nets (now 36%), use of oral rehydration treatment for diarrhoea, and vitamin A supplements has increased significantly<sup>5</sup>
- Maternal mortality has risen from 1100/100 000 births in 1995 to 1500/100 000 in 2000<sup>1</sup>

These data show the potential for obtaining quick gains in child health, where a few specific interventions can make a significant difference. Improving maternal health is much more difficult; increased access to emergency obstetric care requires an integrated, fully functioning health system.

on Vaccines and Immunisation is committed not just to supporting existing vaccines but to providing new ones (such as those against rotavirus and *Pneumococcus*) despite coverage of the established vaccines stagnating—for example, measles coverage has been stuck at 50–60% in sub-Saharan Africa since 1990.<sup>1</sup> In the long term, developing countries will be expected to pay for these inputs, resulting in a massive burden of recurrent expenditure on national budgets.

Global initiatives may bring specific benefits, such as rapid disbursement and exploiting economies of scale, although the effect on vaccine prices has been disappointing to date. On the other hand, these initiatives are causing a dangerous degree of fragmentation and overcrowding of the international health field, and at country level they can distort priorities, undermining country-led approaches and increasing opportunity costs for already overstretched ministries of health. Specific initiatives reinforce the notion that diseases are unfortunate, random occurrences, and allow us to turn a blind eye to the global political and economic conditions that underlie the desperate poverty in Africa.

## An alternative approach

The first part of our alternative approach is to make trade fairer and improve delivery of aid. Investment in basic health care has an important role in improving the quality of life and economic development in Africa, but it must be combined with investment in education, land reform, and democratisation.<sup>12</sup> Renewed focus is also needed on the determinants of poor health, with action taken to tackle the root causes of poverty at both the global and local levels. Across Africa, liberalisation of trade has increased displacement of local industry by large national and international concerns and, coupled with agriculture subsidies in rich countries, depressed commodity prices.<sup>13</sup> African states must be allowed to control the pace of liberalisation and guide development to allow for a more balanced and fairer economy. Urgent action must be taken globally to counter the power of transnational corporations and the effect of their activities on the environment and to challenge the murky trade in arms that fuels Africa's conflicts.

Increased aid potentially provides increased resources for investment in critical sectors, including health. However, for it to have an important and lasting effect on health there must be strong policy support for a broad primary healthcare approach,<sup>14</sup> including increased access for poor people. Thus budget support, although representing a more mature relationship between donor and recipient, may need to be combined with robust dialogue with governments and technical support to ministries of health. Sector-wide approaches developed in several African countries (including Tanzania, Ghana, Uganda, and Zambia) represent a useful model.

## Promote social mobilisation and welfare of poor people

A few success stories in Africa show that broad based approaches can produce large and sometimes sustained improvements in health. For example, in the 10 years

after its independence Zimbabwe secured major improvements in mortality and nutrition of young children, and its experience provided impetus to the strategy of developing district health systems.<sup>15</sup> In Tanzania in the 1980s, villagisation (regrouping scattered populations into villages) informed the large Iringa nutrition programme that led to improved child nutrition as well as the creation of a village level health infrastructure.<sup>16</sup> In these examples, as well as in the experience of countries that are now industrialised and rich,<sup>17</sup> such improvements have been secured through a combination of social policies promoting the welfare of poor people and effective public health interventions.

Successful implementation depends on understanding local practice and preferences rather than on internationally generalised models of how people should behave and what they should want. This in turn relies on the organisational and learning capacities of not just communities but also local health providers and policy makers. A good relationship between healthcare providers and clients is essential.

A starting point, therefore, for a more progressive and effective response is to nurture a different set of values and vision from those that dominate now. Values that inspired many of the struggles for independence across Africa such as equity, social inclusion, and human rights are just as essential today. Clearly, this implies a political dispensation of good governance and leadership accountability—factors that have often proved elusive, particularly in the current context that privileges individual enterprise and devalues social responsibility.

## Increase numbers and capacity of health workers

The implementation of effective health interventions requires, in addition to a favourable sociopolitical con-

### Box 3: Human rights and mobilising civil society

At least 110 national constitutions now make reference to a right to health care. In addition, all African nations are signatories to the Universal Declaration of Human Rights, 1948; the International Covenant on Economic, Social, and Cultural Rights, 1966; the Convention of the Rights of the Child, 1989; and the African Charter on Human and Peoples' Rights, 1981, all of which contain the right to health. Civil society organisations, such as the Treatment Action Campaign in South Africa and ActionAid in Kenya, have successfully used these commitments to apply pressure on African governments to take greater responsibility in providing health care, especially for treatment for AIDS.

Court rulings have pushed the state to speed up the delivery of drugs to prevent mother to child transmission of HIV and for AIDS treatment. However, persistent weaknesses in health systems are hampering the scaling up of these interventions. Civil society organisations have a crucial role in mobilising different communities to provide additional financial, human, and technical resources to help deliver treatment programmes and monitor implementation. A rights based approach is being used across the continent to increase access to and monitor quality of services.

text, adequate technical capacity. Innovative approaches to developing capacity, such as health systems research including policy makers and practitioners, continuing education, and ongoing support all require commitment from local research and academic institutions. Rehabilitation of Africa's universities and research institutions to enable them to give this commitment will require considerable funding.<sup>18</sup>

Other urgent measures are necessary to revive Africa's failing health systems. A key imperative is to rapidly increase numbers of health workers and improve their functioning. Funds alone will be insufficient. Retention policies, including financial and non-financial incentives such as accelerated training, support, and supervision, are crucial.<sup>18</sup> Effective mechanisms to limit or compensate for emigration of health workers are also needed. Current initiatives such as voluntary codes on recruitment have not worked, and attracting back Africans who have specialised overseas may strengthen the lobby for high-tech approaches to health care.

### Strengthen the community base of health care

The HIV pandemic and community response to the availability of antiretroviral drugs show how mobilisation around basic health issues can start to create a more favourable political context (box 3). The pandemic has also highlighted the urgent need to strengthen Africa's health systems, especially at primary and community levels. Although government services have been slow to respond, many innovative programmes have been developed by non-governmental and community based organisations, including initiatives providing advocacy for treatment and access to care for orphans. These services are often delivered by volunteer and community health workers, supported in particular by faith based groups. They often constitute the only point of access for the poor and are an important component of the revitalisation of African health systems.

### Conclusion

In 1978, the international community made a visionary commitment to primary health care that emphasised equity, community participation, health promotion, intersectoral approaches, appropriate technology, effectiveness, and accessibility.<sup>14 19</sup> This commitment remains important for modern African health systems. Indeed, the challenges posed today, especially HIV and AIDS, make it even more relevant. The fundamental solutions to Africa's health problems lie with African people themselves. The main duty of the international community is to create the conditions that will allow Africa to develop and flourish.

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1 World Bank Group. *Millennium development goals*. <http://ddp-ext.worldbank.org/ext/MDG/home.do> (accessed 25 Sep 2005).

### Summary points

Sustainable improvements in health in Africa require tackling the root causes of poverty, including the global economic order and corruption

Currently favoured international approaches will at best have a limited effect and may be counterproductive

Social mobilisation, a strengthened community base, and increased numbers and capacity of health workers lie at the heart of an alternative approach based on primary health care

The international community must create favourable conditions for development in Africa by, for example, making trade fairer and limiting the arms trade

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### Profiles of local African organisations doing research

We solicited profiles of community based organisations doing research and development work in Africa. Many groups responded, and their profiles are posted (as supplied) on [bmj.com](http://bmj.com). A great many indigenous organisations are not included here. We invite you to post a rapid response on [bmj.com](http://bmj.com) to share your community research projects, including both the successes and the challenges.

<http://bmj.bmjournals.com/cgi/content/full/331/7519/758/DC1>